CRAFT

CITIZENS RESEARCH ALLIANCE FOR THERAPEUTICS
MEMBERSHIP AGREEMENT

TO BE FILLED OUT BY PATIENT:
Full Name:_____
Address: _____
Telephone:_____
Telephone: _____
Email Address:_____
Date of Birth:_____
CA Driver's License / ID Card No: _____
Expiration Date: _____
Medical Cannabis Recommendation No: _____

PRESCRIBING PHYSICIAN'S INFORMATION
Physician Name: _____
Verification Web Address: _____
Phone No: _____

MEDICAL RELEASE
I hereby authorize my treating Physician, as required by State and Federal Laws, including HIPAA regulations, to release my medical information concerning my diagnosis, condition, and/or prescription to CITIZENS RESEARCH ALLIANCE FOR THERAPEUTICS and its duly authorized representatives.

Patient Signature: _____ Date: _____

The undersigned further affirms that is a qualified patient pursuant to the California Compassionate Use Act of 1996, ("CUA"), codified as Health & Safety Code 11362.5. The undersigned acknowledges that CRAFT is relying upon the accuracy and completeness of the representations contained herein in complying with its obligations under applicable state laws. The undersigned acknowledges and represents as follows:
a. I have been given access to a full and complete copy of the terms and conditions of CRAFT and have utilized such access to my satisfaction, or waived the opportunity to do so, for the purpose of asking questions and receiving answers concerning the terms and conditions of membership in CRAFT.

Patient/Member Initial: ___

b. I hereby appoint and designate CRAFT, and its representatives and agents, as my agent for purposes of assisting me in obtaining marijuana for the treatment of my medical condition, pursuant to California Health and Safety Code §§ 11362.775, 11362.765, and the California Attorney General Guidelines.

Patient/Member Initial: ___

c. I hereby grant CRAFT all power and authority to cultivate, possess, transport, distribute and manufacture marijuana on my behalf. I hereby authorize CRAFT to possess my proportional share of the medication until I have made arrangements to take custody of the medicine.

Patient/Member Initial: ___

By execution below, the undersigned acknowledges receipt of the terms and conditions form, and agrees to abide by all terms and conditions set forth within said form. The undersigned further acknowledges and understands that non-compliance with any term or condition will result in immediate cancellation of membership and loss privileges, and that authorized agents of CITIZENS RESEARCH ALLIANCE FOR THERAPEUTICS retain the right to cancel membership for any reason, at any time.

SIGNATURE FOR INDIVIDUALS:
Dated:_____
Signature:_____
Name(s) Typed or Printed:_____

APPROVED AND ACCEPTED this ____ day of _____
CITIZENS RESEARCH ALLIANCE FOR THERAPEUTICS

By:_____
Authorized Agent of
CITIZENS RESEARCH ALLIANCE FOR THERAPEUTICS